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**Dialogue Summary:
Addressing the Integration of Nurse Practitioners in Primary Healthcare Settings in Canada**

6 July 2011

McMaster Health Forum

For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at the regional/provincial level and at national levels, the Forum harnesses information, convenes stakeholders, and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions, and communicate the rationale for actions effectively.

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Conflict of interest

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SUMMARY OF THE DIALOGUE

Several dialogue participants noted that unmet needs in primary healthcare settings are now less about numbers of primary healthcare providers (particularly physicians) and more about:

- 1) particular populations that are not now well served in primary healthcare; and
- 2) timeliness of access to primary healthcare for many Canadians.

A number of dialogue participants argued that making the case for nurse practitioners to be part of the solution in addressing these unmet needs, particularly in a time of fiscal restraint and after an extended period of investment in primary healthcare, requires working through where nurse practitioners can best fit into ongoing system re-design and for which populations (and then in which settings).

Many dialogue participants argued that two multi-stakeholder processes were needed with:

- 1) one national initiative to ‘refresh’ the primary healthcare principles that should govern ongoing primary healthcare system re-design, with one or more principles addressing the importance of: a) teams in providing primary healthcare, b) nurse practitioners as one example of a potentially key member of primary healthcare teams, and c) neither physicians nor nurse practitioners (nor other professions) working in isolation; and
- 2) a set of provincial/territorial primary healthcare reform working groups to address a number of questions related to best meeting patients’ primary healthcare needs.

Many dialogue participants supported the idea of two types of information/education campaigns:

- 1) one campaign targeted at the general public to raise awareness of primary healthcare innovations (some of which will include nurse practitioners) providing timelier access to broad groups and/or improved care to specific groups; and
- 2) a second campaign targeted at primary healthcare professionals and focused on best practices in team-based care, including how collaborative practice can function to the benefit of their patients and themselves.

A number of dialogue participants agreed that continued work is needed to ensure that:

- 1) regulations governing nurse practitioners are more consistent across provinces and territories;
- 2) educational standards for nurse practitioners are in place in all provinces and territories; and
- 3) interprofessional education is in place in all provinces (and territories, where feasible).

Many dialogue participants emphasized that primary healthcare community building also warranted attention.

Two implementation considerations emerged repeatedly over the course of the deliberations:

- 1) continuing opposition (or lack of support) by some medical associations and conflicting messages among nurse practitioners about some key issues; and
- 2) the lack of voice for primary healthcare professionals as a group (as opposed to their respective professionally defined sub-groups).

The need for a two-stage process as a key feature of any implementation strategy was also noted at several points over the course of the deliberations, with the first stage focusing on the multi-stakeholder initiative and working groups, information/education campaigns, and continued work on achieving educational and regulatory consistency across the country, and the second stage focusing on the much more difficult structural changes to the primary healthcare sub-system.

SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT THE PROBLEM

Dialogue participants discussed both the overall framing of the problem as the lack of full integration of nurse practitioners in primary healthcare settings, and the specific features of the problem that had been described in the issue brief. Many dialogue participants agreed with many of the problem features as they were described, including that demands on primary healthcare are growing, the care being delivered in many primary healthcare settings is not as timely or as high quality as patients want and need it to be, and current health system arrangements (such as physician-payment mechanisms) are contributing to the problem. However, a number of dialogue participants argued strongly that a comprehensive understanding of any problems in primary healthcare settings needs to start with patients and not with a single health profession (such as nurse practitioners) or an ill-defined objective of full integration for that profession (which could mean a role in governance, a broader scope of practice, payment mechanisms that support many types of practice, a significant increase in supply, no incentives for particular distributions by population group or geographic location, or something else). Some dialogue participants felt that the focus on a single profession left the impression that nurse practitioners are a ‘solution looking for a problem,’ while others argued that most past debates have implicitly or explicitly adopted a physician-centric view of primary healthcare, and that there is an important role for looking at this sub-system through the lens of other health professions.

Several dialogue participants argued that the most pressing problem in primary healthcare is that three types of information are currently lacking at regional and provincial/territorial levels:

- 1) which populations need which combinations of programs and services in primary healthcare settings and with what timeliness of access;
- 2) which combinations of healthcare professionals are needed to deliver these programs and services; and
- 3) how the right combinations of healthcare professionals can be supported to deliver these programs and services.

One dialogue participant noted that if one part of the answer to the first question is support for self-management then the answer is much less likely to be physicians than other professions such as nurse practitioners.

Box 1: Background to the stakeholder dialogue

The stakeholder dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action. Key features of the dialogue were:

- 1) it addressed an issue currently being faced in Canada;
- 2) it focused on different features of the problem, including (where possible) how it affects particular groups;
- 3) it focused on three elements of an approach (among many) for addressing the policy issue;
- 4) it was informed by a pre-circulated issue brief that mobilized both global and local research evidence about the problem, three elements of a comprehensive approach for addressing the problem, and key implementation considerations;
- 5) it was informed by a discussion about the full range of factors that can inform how to approach the problem and possible elements of an approach for addressing it;
- 6) it brought together many parties who would be involved in or affected by future decisions related to the issue;
- 7) it ensured fair representation among policymakers, stakeholders and researchers
- 8) it engaged a facilitator to assist with the deliberations;
- 9) it allowed for frank, off-the-record deliberations by following the Chatham House rule: “Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed”; and
- 10) it did not aim for consensus.

Participants’ views and experiences and the tacit knowledge they brought to the issues at hand were key inputs to the dialogue. The dialogue was designed to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue and by those who review the dialogue summary and the video interviews with dialogue participants.

Several other dialogue participants made a complementary point, noting that unmet needs in primary healthcare settings are now less about numbers of primary healthcare providers (particularly physicians) and more about:

- 1) particular populations that are not now well served in primary healthcare; and
- 2) timeliness of access to primary healthcare for many Canadians.

Another dialogue participant noted that we also need to think about what needs will look like in future, not now. This individual pointed out that ‘the aging of the population and the growing burden of chronic diseases will make everything different,’ giving as an example how sick patients with complex chronic conditions who would once have been treated in a hospital are now being treated in the community. Another individual agreed, noting that our problems will be compounded if these needs are all medicalized as they have been in the past, and not examined from multiple perspectives as they would be by a broader array of types of team members.

One dialogue participant cautioned that discussions about addressing such unmet needs require awareness that Canadian federal, provincial and territorial governments are all currently in a time of fiscal restraint, and many are coming out of an extended period of investment in primary healthcare. Tough questions will therefore be asked both about what was achieved for patients from previous investments in addressing unmet needs in primary healthcare settings (and inadequate answers may jeopardize the sustainability of these investments), and how solid is the case for making any new investments.

A number of dialogue participants pointed out that existing health system arrangements hamper efforts to support the right combinations of healthcare professionals to provide timely access to needed programs and services in primary healthcare settings (even if our current understanding of patients’ needs and optimal combinations of professionals is very inexact). These participants argued that while attention is being given to the problem of finding and digesting information at regional and provincial/territorial levels about different population groups’ needs and the optimal combinations of health professionals needed to address those needs, significant attention should also be given to the problem of existing health system arrangements (or what some dialogue participants called ‘structural problems’ in primary healthcare).

Dialogue participants gave a number of examples of problems with existing health system arrangements. For example, several dialogue participants noted that in a number of provinces and territories many physicians continue to be paid on a fee-for-service basis for the care that they provide, or that professionals working for them provide (and not as members of a team that is paid as a group for efficiently providing timely access to high quality primary healthcare for defined groups of patients). One dialogue participant noted that a sizeable proportion of these physicians see themselves as the independent owners of private businesses and not as key contributors to achieving shared primary healthcare goals and objectives. Another dialogue participant noted that one could ‘do more harm than good if nurse practitioners are used as a band-aid’ on a sub-system with many points of weakness. Moreover, dialogue participants noted the absence of training and supports for creating and sustaining interprofessional primary healthcare teams whose members work collaboratively towards common goals. One dialogue participant noted the simultaneous absence of governance bodies, leadership capacity, administrative skills and decision supports within the primary healthcare sub-system. Also, one dialogue participant noted that there is no legal basis for primary healthcare in Canada (as there is now with the Canada Health Act for hospital-based and physician-provided healthcare), and there is little direct provincial/territorial or federal government support for primary healthcare infrastructure (as there is provincial/territorial government support for infrastructure in acute healthcare settings and federal government support – through Canada Health Infoway – for electronic health records across many types of settings).

Dialogue participants noted that if nurse practitioners are deemed to be key members of the team needed to deliver programs and services to particular populations (or all Canadians) then at least some existing health

system arrangements would need to change. However, one dialogue participant argued that information is currently lacking about nurse practitioners' views on the subjects of:

- 1) how should nurse practitioners be paid;
- 2) what is the optimal number of patients for each nurse practitioner;
- 3) should nurse practitioners be expected to be available (or to make arrangements to ensure someone is available) 24 hours a day, seven days a week;
- 4) what can be done to ensure that the distribution of nurse practitioners across populations (defined by need, geography or other factors) is optimal; and
- 5) for which populations and in which settings do nurse practitioners have the best chance of integrating successfully and having an impact.

This participant argued that, without such information, the redesign of existing health system arrangements in order to support nurse practitioners and other healthcare professionals to deliver needed programs and services is likely to be driven by the views of other professional groups.

Some dialogue participants argued that some work has already been done to solicit the views of nurse practitioners about optimal supports, but most agreed that more work needs to be done and the results of that work communicated effectively. Indeed, some misunderstandings arose during the dialogue about one or two dialogue participants' views about preferred practice arrangements for nurse practitioners (e.g., whether they would work as fully independent primary healthcare providers or as part of a team that also includes physicians, among others) and whether these were widely held among nurse practitioners, which one dialogue participant noted is inevitable within any professional group. Certainly there was a spectrum of views among medically trained dialogue participants about preferred practice arrangements for physicians. Nevertheless several dialogue participants noted that leaders within the nurse practitioner community will need to communicate effectively about where the balance of views lies on these critical issues (at least in their interactions with governments).

Several dialogue participants noted that there is some urgency to working through whether nurse practitioners are going to be key members of the primary healthcare team, for which types of populations, and with what types of supportive health system arrangements. Without some answers to these questions, there is significant potential that personal and public investments in their training will be wasted, particularly as opportunities for nurse practitioners are crowded out by the rising numbers of physicians (including internationally trained medical graduates), rising proportions of physicians choosing careers in primary healthcare, continuing use of physician-payment mechanisms that introduce a competitive dynamic between physicians and nurse practitioners, and introductions of new health professions such as physician assistants whose employment status does not give rise to a competitive dynamic. One dialogue participant cautioned that these trends need to be understood in the context of other trends that could mean greater opportunities for nurse practitioners, such as many physicians wanting a more balanced working life. A second dialogue participant noted that nurse practitioners have often suffered at the hands of 'knee-jerk' responses to the first category of trends in the past. A third dialogue participant noted that the potential for wasted investments is all the more troubling given the robust findings about the safety and effectiveness of nurse practitioners in primary healthcare settings that were documented in the issue brief and which no dialogue participant questioned. What one dialogue participant did question was whether some nurse practitioners were over-reaching in their quest to expand their scopes of practice in directions that have not been the subject of study.

DELIBERATION ABOUT ELEMENTS OF AN APPROACH FOR ADDRESSING THE PROBLEM

Dialogue participants discussed three elements of an approach that had been previously endorsed by a broad-based group of key stakeholders and that had been examined in the issue brief. Many dialogue participants agreed that each of the three elements held promise either with a re-framing of the focus of the proposed activities (elements 1 and 3) or with an emphasis on continuing activities that are already achieving results (element 2). Many dialogue participants also agreed that a fourth element – primary healthcare community building – also held promise.

Dialogue participants' discussions of the three elements were complicated by cross-professional differences in views about the optimal role of physicians and nurse practitioners in primary healthcare, and by cross-provincial differences in knowledge about the current state of primary healthcare investments and reforms across the country. The cross-professional differences in views turned out to have been due in part to a misunderstanding about what select individuals were advocating in terms of nurse practitioners' relationship to physicians (independent, which is seen as a 'deal breaker' by some physicians, or collaborator), which was resolved near the end of the stakeholder dialogue. However, there appeared to be genuinely different views about physicians' relationship to primary healthcare teams (leader or member). The cross-provincial differences in knowledge were addressed over the course of the stakeholder dialogue as different dialogue participants came to realize that their experience in British Columbia, Ontario or Quebec might be very different from the experience of those in other provinces (and territories).

Element 1 - Launch a multi-stakeholder strategic-planning initiative

A number of dialogue participants agreed that two types of multi-stakeholder initiatives were needed to further strengthen primary healthcare, with neither focusing narrowly on addressing the integration of nurse practitioners in primary healthcare settings in Canada, but with both potentially giving this specific issue attention if early steps in the process indicated it was needed.

A number of dialogue participants agreed that one of two multi-stakeholder initiatives could be a national initiative to 'refresh' the primary healthcare principles that should govern ongoing primary healthcare system redesign (and that were first developed through a multi-stakeholder initiative – Enhancing Interdisciplinary Collaboration in Primary Health Care – supported by the Primary Health Care Transition Fund). One or more principles could address the importance of:

- 1) teams in providing primary healthcare;
- 2) nurse practitioners as an example of one potentially key member of primary healthcare teams; and
- 3) neither primary care physicians nor nurse practitioners (nor other professions) working in isolation.

The initiative could helpfully serve to re-connect the many groups involved in strengthening primary healthcare across the country and to foster cross-jurisdictional learning. These groups lost a regular forum for sharing lessons learned when the time-limited Primary Health Care Transition Fund ceased operation. The initiative could also be supported by organizations such as the Canadian Health Services Research Foundation and the Health Council of Canada, which are already devoting significant attention to the topic of strengthening primary healthcare. Moreover, those leading any such initiative could draw lessons from the national initiatives that documented the 'burning platform' for improving cancer control and mental health across the country. One dialogue participant noted that some of these lessons included 'having a very big tent' (with provincial/territorial associations, non-governmental organizations, patients and researchers involved), articulating clearly what the 'burning platform' is, and making a very specific 'ask' of government.

These dialogue participants also tended to agree that the second of two multi-stakeholder initiatives could be multi-stakeholder provincial/territorial primary healthcare reform working groups that work through:

- 1) which populations need which combinations of primary healthcare programs and services;
- 2) which combinations of healthcare professionals are needed to deliver these programs and services; and
- 3) how the right combinations of healthcare professionals can be supported to deliver these programs and services.

These groups would also benefit from the national initiative described above as well as by support provided by primary healthcare researchers, some of whom would include those with expertise in the role of nurse practitioners in primary healthcare. One individual noted that ‘as we incrementally change the system, there will be many opportunities to introduce nurse practitioners.’ Another individual noted that these working groups will also be needed at the local level, not just at the provincial/territorial level. A third individual argued that constructive face-to-face engagement was needed from the local practice level right up to the national association level, given that past experience with nurse practitioners, midwives and pharmacists has shown that agreements can be hardest to achieve when a profession’s ‘scope of practice comes up against a physician monopoly and incomes,’ as well as (in the words of another participant) ‘their wish not to lose the easy stuff’ in their daily work to other professions. Another dialogue participant placed even greater emphasis on the local level, arguing that ‘integration happens clinic by clinic.’

Dialogue participants had mixed views about the helpfulness of working through how nurse practitioners as a group view the key issues that will inevitably arise during any national and provincial/territorial initiatives to strengthen primary healthcare, which include (as described previously):

- 1) how should nurse practitioners be paid;
- 2) what is the optimal number of patients for each nurse practitioner;
- 3) should nurse practitioners be expected to provide cover 24 hours a day, seven days a week;
- 4) what can be done to ensure that the distribution of nurse practitioners across populations (defined by need, geography or other factors) is optimal; and
- 5) for which populations and in which settings do nurse practitioners have the best chance of integrating successfully and having an impact.

Some dialogue participants argued that this work was essential to do and that it could be supported by groups like the Canadian Nurses Association, others argued that the work had already been done, and still others argued that it would be difficult to do this work in the absence of an imperative from government (because it would raise expectations among nurse practitioners yet potentially find no interested audience).

Some dialogue participants argued that over the longer term what is really needed is structural change to the primary healthcare sub-system within the broader health system, which could mean:

- 1) transformative steps such as provincial/territorial governments changing the sub-system in which many physicians are being paid on a fee-for-service basis for the care that they provide or that professionals working for them provide, to a sub-system in which members of a team are paid as a group for efficiently providing timely access to high quality primary healthcare for defined groups of patients; and
- 2) facilitating steps such as the federal government establishing a legal basis for primary healthcare, much like the Canada Health Act does for hospital-based and physician-provided healthcare now, and providing funding for primary healthcare infrastructure, much like Canada Health Infoway does for electronic health records.

Element 2 - Support consistency in standards, requirements and processes

Many dialogue participants agreed that continued work is needed to ensure that:

- 1) regulations governing nurse practitioners are consistent across provinces and territories;
- 2) educational standards for nurse practitioners are in place in all provinces and territories; and
- 3) interprofessional education is in place in all provinces (and territories, where feasible).

A number of dialogue participants pointed out that educational groups and regulatory bodies meet regularly, that they had already accomplished a great deal in terms of consistency in educational and regulatory standards (e.g., having the core competency framework for nurse practitioners adopted across all provinces except Quebec), and that they have additional work underway, which simply needs to continue.

A few dialogue participants felt that there are still important inconsistencies in regulations and educational standards that need to be addressed as soon as possible. Other dialogue participants reminded the group of the very large volume of changes that are needed across the country to allow nurse practitioners to practise to their full scope of practice even once key regulations and educational standards are in place. One dialogue participant gave legislation and regulations about vital records at the provincial level as an example of a specific policy that needed to be changed in one province, while another gave the example of legislation and regulations about controlled substances at the federal level. Other dialogue participants noted that even when regulations and educational standards provide for a certain scope of practice, employers may not allow nurse practitioners to practise to their own scope.

Several participants expressed surprise that the pathway used for medical specialties and sub-specialties – a national educational standard is established, provincial regulatory colleges then make the changes needed to enshrine this standard, and specialty training programs develop their curriculum and go through an accreditation process – is not the same as the one used for nurse practitioners. For nurse practitioners it is the regulators who play the more dominant role; yet, as one dialogue participant said, they often leave a great deal of latitude to educational institutions (e.g., they might require that a curriculum be in place, but not provide the specifics on the nature of the curriculum). Moreover, there is no national accreditation process for training programs.

Element 3 - Launch an information/education campaign

A number of dialogue participants also agreed that an information/education campaign targeted at patients is needed to highlight primary healthcare innovations that are enabling physicians and the teams that they're a part of to provide timelier access to broad groups of patients and/or improved care to specific groups of patients. The campaign could raise awareness about how nurse practitioners and other healthcare professionals are working alongside physicians (and not, in the words of one participant, 'as a physician substitute'), both to prepare patients for seeing these other professionals in primary healthcare settings (and not just their overburdened physicians) and to build support for ongoing efforts to innovate in primary healthcare delivery (and not just, as one dialogue participant said, 'for the training of more physicians or the better remuneration of physicians'). As one dialogue participant said: 'the ideal image is of a patient saying "this is my primary healthcare team" while surrounded by a physician, a nurse practitioner, a physiotherapist, a pharmacist' and possibly others. To complement this campaign, some dialogue participants suggested a second campaign targeted at primary healthcare professionals and focused on best practices in team-based care, including how collaborative practice can function to the benefit of their patients and themselves, how teams can negotiate the roles that will be played by each member of the team, and how partnership agreements can be developed.

Some dialogue participants argued that information/education campaigns could have national elements, but that cross-provincial differences in the status of primary healthcare reform efforts warranted province-/territory-specific campaigns in at least some provinces and territories. One dialogue participant noted that change will not come from ‘the elite talking... but from grass-roots level’ innovations and best practices.

Considering the full array of elements

Many dialogue participants agreed that the idea of launching a multi-stakeholder strategic planning initiative to address the integration of nurse practitioners in Canada (element 1) needed to be re-framed as launching two multi-stakeholder processes with:

- 1) one national initiative to ‘refresh’ the primary healthcare principles that should govern ongoing primary healthcare system redesign; and
- 2) a set of provincial/territorial primary healthcare reform working groups to address a number of questions related to best meeting patients’ primary healthcare needs.

Some dialogue participants also argued that these multi-stakeholder initiatives could be helpfully complemented by a nurse practitioner-focused initiative to work through how they as a group view the key issues that will inevitably arise (such as payment mechanism) during the multi-stakeholder initiatives.

Many dialogue participants also agreed that the idea of launching an information/education campaign to raise awareness of the value-added role of nurse practitioners in primary healthcare settings (element 3) needed to be re-framed as launching an information/education campaign to raise awareness of primary healthcare innovations that are enabling physicians and the teams that they’re a part of (which increasingly include nurse practitioners) to provide timelier access to broad groups and/or improved care to specific groups.

A number of dialogue participants also agreed that the idea of supporting consistency in educational and regulatory standards, requirements and processes for nurse practitioners across the country (element 2) needed to instead emphasize *continuing* activities that are already underway to support consistencies in education and regulation.

Many dialogue participants also agreed that a fourth element – primary healthcare community building – also warranted attention. A number of participants argued that, while lessons can be learned from single-jurisdiction, model-specific organizations like the Association of Family Health Teams of Ontario, what is now needed is an organization that can unite primary healthcare providers and managers from across the country and from all types of models of primary healthcare delivery. Such an organization could complement the health professional associations that adopt a profession-specific lens to their efforts to influence the direction and shape of primary healthcare in Canada, much as organizations representing acute care, mental health and select acute and chronic diseases do.

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

Regrettably the deliberation about implementation considerations was cut short by a fire alarm, which meant that dialogue participants had to leave the room for a significant period. However, two implementation considerations that were described in the issue brief did emerge repeatedly as issues over the course of the deliberations (as did steps to address these considerations, which are in part the focus of the next section):

- 1) continuing opposition (or lack of support) by some medical associations (or by vocal groups within some medical associations), on the one hand, and conflicting messages among nurse practitioners about how they view key issues about how they will work with physicians and function within the primary healthcare sub-system, on the other hand; and

- 2) the lack of voice for primary healthcare professionals as a group (as opposed to their respective professionally defined sub-groups).

The need for a two-stage process as a key feature of any implementation strategy was also noted at several points over the course of the deliberations. Some dialogue participants argued that the first stage should focus on the multi-stakeholder initiative and working groups, information/education campaigns, and continued work on achieving educational and regulatory consistency across the country. These participants argued the second stage should focus on structural changes to the primary healthcare sub-system, such as moving from physicians being paid on a fee-for-service basis for the care that they or their staff provide to teams being paid as a group for efficiently providing timely access to high quality primary healthcare for defined groups of patients.

One dialogue participant offered two ‘red flags’ to keep in mind with any implementation strategy:

- 1) don’t impose top-down solutions; and
- 2) don’t introduce any changes that will further fragment care.

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

The deliberations about next steps focused on the first stage of the proposed two-stage process and reiterated many of the points from early deliberations.

A number of dialogue participants agreed that one of two key next steps could be to convene a national, multi-stakeholder initiative to ‘refresh’ the primary healthcare principles that should govern ongoing primary healthcare system redesign. One or more principles could address the importance of:

- 1) teams in providing primary healthcare;
- 2) nurse practitioners as an example of one potentially key member of primary healthcare teams; and
- 3) neither primary care physicians nor nurse practitioners (nor other professions) working in isolation.

They argued that the initiative could helpfully serve to re-connect the many groups involved in strengthening primary healthcare across the country. These groups lost a regular forum for sharing lessons learned when the Primary Health Care Transition Fund ceased operation. One dialogue participant argued that the most important principle would be what the system should achieve (e.g., enhanced patient experience, better outcomes and reduced/controlled per capita cost of care), and that another principle should be about the need for structures and processes that bring patients, providers and health system leaders together to govern the primary healthcare sub-system.

The second of two key next steps could be to provide support to multi-stakeholder provincial/territorial primary healthcare reform working groups to work through:

- 1) which populations need which combinations of programs and services;
- 2) which combinations of healthcare professionals are needed to deliver these programs and services; and
- 3) how the right combinations of healthcare professionals can be supported to deliver these programs and services.

These groups would also benefit from the type of national initiative described as the first key next step.

Dialogue participants expressed mixed views about the helpfulness of working through how nurse practitioners as a group view the key issues that will inevitably arise during these next steps at the national and provincial/territorial levels:

- 1) how should nurse practitioners be paid;
- 2) what is the optimal number of patients for each nurse practitioner;
- 3) should nurse practitioners be expected to provide cover 24 hours a day, seven days a week;
- 4) what can be done to ensure that the distribution of nurse practitioners across populations (defined by need, geography or other factors) is optimal; and

- 5) for which populations and in which settings do nurse practitioners have the best chance of having an impact.

Regarding the key issue of which are the populations and settings where nurse practitioners could have the greatest impact, one dialogue participant said it could be one or more of disease prevention and health promotion, cancer care, chronic disease management (especially case management and supporting self-management), geriatric care, mental healthcare and long-term care. Some dialogue participants argued that this work had already been done, while others argued that it would be difficult to do this work in the absence of an imperative from government (because it would raise expectations among nurse practitioners yet potentially yield nothing).

A number of dialogue participants also agreed that an information/education campaign is needed to highlight primary healthcare innovations that are enabling physicians and the teams that they're a part of to provide timelier access to broad groups and/or improved care to specific groups. The campaign could raise awareness about how nurse practitioners and other healthcare professionals are working alongside physicians, both to prepare patients for seeing these other professionals in primary healthcare clinics and to build support for ongoing efforts to innovate in primary healthcare delivery. To complement this campaign, some dialogue participants suggested a second campaign targeted at primary healthcare professionals and focused on best practices in team-based care, including how collaborative practice can function to the benefit of their patients and themselves.

Many dialogue participants agreed that continued work is needed to ensure that:

- 1) regulations governing nurse practitioners are more consistent across provinces and territories;
- 2) educational standards for nurse practitioners are in place in all provinces and territories; and
- 3) interprofessional education is in place in all provinces (and territories, where feasible).

Finally, a number of dialogue participants agreed that primary healthcare community building is urgently needed, and specifically an organization that can unite primary healthcare providers and managers from across the country and from all types of models of primary healthcare delivery. Such an organization could complement the health professional associations that adopt a profession-specific lens to their efforts to influence the direction and shape of primary healthcare in Canada, much as organizations representing acute care, mental health and select acute and chronic diseases do.